UNIVERSAL INTAKE FORM

Funding Identifier: Title III B ☐ C1 ☐ C2 ☐ Title III D ☐ Title III E ☐ Title III E(G) ☐ Linkages ☐

CLIENT DEMOGRAPHICS

1	Applicant Last Name	First Name	Middle Initial	Client ID #

Home Address *(Number/Street)*	City	State	Zip Code

Home Phone	Work Phone	Cell Phone

Birth Date	Age	Gender	Transgender
		☐ Male ☐ Female ☐ Declined to State	☐ Yes ☐ No

Mailing Address *(If different than home address)*	City	State	Zip Code

Email Address

Veteran	Spouse of Veteran	Veteran #
☐ Yes ☐ No	☐ Yes ☐ No	

Client Race

☐ White ☐ American Indian or Alaska Native ☐ Chinese ☐ Japanese ☐ Filipino ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian ☐ Cambodian ☐ Other Asian ☐ Black or African American ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Multiple Race ☐ Declined to State

Client Ethnicity

☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State

Relationship Status

☐ Single (Never Married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined to State

Type of Residence	Rural Designation	Unincorporated City
☐ House ☐ Apartment ☐ Hotel ☐ Mobile Home ☐ Nursing Home ☐ Residential Care Home ☐ Room and Board ☐ Homeless ☐ Other	☐ Rural ☐ Urban ☐ Declined to State	☐ Yes ☐ No

Living Arrangement	Does the individual (*Optional*)
☐ Alone ☐ Not Alone ☐ Declined to State	☐ Rent ☐ Own ☐ Other

Primary Language Spoken

☐ American Sign Language ☐ Arabic ☐ Armenian ☐ Cambodian ☐ Cantonese ☐ Chinese ☐ English ☐ Farsi ☐ French ☐ Korean ☐ Laotian ☐ Mandarin ☐ Japanese ☐ Russian ☐ Spanish ☐ Tagalog ☐ Thai ☐ Vietnamese ☐ Other

Translation needed ☐ Yes ☐ No

EMERGENCY CONTACT

2

Contact Last Name	First Name	Middle Initial

Address *(Number/Street)*	City	State	Zip Code

Home Phone	Work Phone	Cell Phone	Relationship

Contact Name: (*Last, First, Middle Initial*) – *Optional*

Address *(Number/Street)*	City	State	Zip Code

Home Phone	Work Phone	Cell Phone	Relationship

Physician's Name	Office Phone

Physician's Address	City	State	Zip Code

FINANCIAL/BENEFITS

3

Are you currently receiving Social Security Benefits? ☐ Yes ☐ No	What benefit(s) are you receiving?	Social Security # (*Optional*)

Do you have Health Insurance? ☐ Yes ☐ No	Health Insurer's Name	Policy Number: *(Optional)*

Do you receive Medi-Cal? ☐ Yes ☐ No	Medi-Cal # *(Optional)* Issue date:	Do you receive Medicare? ☐ Yes ☐ No

Do you receive In-Home Supportive Services *(IHSS)?* ☐ Yes ☐ No

Is your personal income at or below Federal Poverty Level? ☐ Yes ☐ No ☐ Declined to State

Employment Status *(Check One)*

☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Declined to State

REFERRAL INFORMATION

4

Referral Source	Referral Source relationship to client

Last Name	First Name	Phone

Address	City	State

Interview Mode ☐ Face-to-Face (*Appointment*) ☐ Telephone ☐ Drop-In ☐ In-Home

Presenting Problems/Services Requested/Comments/Follow-up:

NUTRITIONAL RISK FACTORS

5 NUTRITIONAL RISK

(Add the numbers from each checked box to determine Nutrition Risk Score)

2 - Has an illness or condition that has changed the kind and/or amount of food eaten	□Yes	□ No	□ Declined to State
3 - Eats fewer than 2 meals per day	□ Yes	□ No	□ Declined to State
1 - Eats few fruits, vegetables	□ Yes	□ No	□ Declined to State
1 - Eats or drinks very few milk products	□ Yes	□ No	□ Declined to State
1 - Drinks less than 5 cups (8 oz. per cup) of fluids a day	□ Yes	□ No	□ Declined to State
1 - Has 3 or more alcoholic beverages per day	□ Yes	□ No	□ Declined to State
2 - Has tooth or mouth problems that make it hard to eat	□ Yes	□ No	□ Declined to State
4 – Does not always have enough money to buy needed food	□ Yes	□ No	□ Declined to State
1 - Eats alone most of the time	□ Yes	□ No	□ Declined to State
1 - Takes 3 or more prescribed or over-the-counter medications a day	□ Yes	□ No	□ Declined to State
2 - Has involuntarily lost or gained 10 pounds in the last 6 months	□ Yes	□ No	□ Declined to State
2 - Is not always physically able to shop, cook and/or eat	□ Yes	□ No	□ Declined to State

Total Nutritional Risk Score: _____ (If total is 6 or more, participant is at **High** Nutritional Risk)

ADL / IADL RISK FACTORS

6 ACTIVITIES OF DAILY LIVING (ADL) / INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

Excluding Title III E Caregiver Program

Activities of Daily Living *(ADL)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Eating	□	□	□	□	□	□
Bathing	□	□	□	□	□	□
Toileting	□	□	□	□	□	□
Transferring	□	□	□	□	□	□
Walking	□	□	□	□	□	□
Dressing	□	□	□	□	□	□

Instrumental Activities of Daily Living *(IADL)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Meal preparation	□	□	□	□	□	□
Shopping	□	□	□	□	□	□
Med. Mgmt.	□	□	□	□	□	□
Money Mgmt.	□	□	□	□	□	□
Using Phone	□	□	□	□	□	□
Hvy. Housework	□	□	□	□	□	□
Lt. Housework	□	□	□	□	□	□
Transportation	□	□	□	□	□	□

DISABILITY FACTORS

Disability

☐ Visually Impaired ☐ Hearing Impaired ☐ Physically Impaired ☐ Cognitively Impaired ☐ Declined to State

☐ None

Diabetic

☐ Yes ☐ No

Have you been diagnosed with Alzheimer's or a related neurological disorder?

☐ Yes ☐ No

TITLE III E CARE RECEIVER DEMOGRAPHICS

7 TITLE III E CARE RECEIVER DEMOGRAPHICS

Please make additional copies of Section 7 & 8 if more than one Care Receiver

Caregiver Relationship: ☐ Husband ☐ Wife ☐ Domestic Partner ☐ Grandparent ☐ Son/Son-in-Law ☐ Daughter/Daughter-in-Law ☐ Other Relative ☐ Non-Relative ☐ Declined to State

Care Receiver Last Name	First Name	Middle Initial	Care Receiver Participant ID #

Address (Number & Street)	City	State:	Zip Code

Home Phone	Work Phone	Cell Phone	Emergency Contact Phone

Birth Date	Age	Gender	Transgender
		☐ Male ☐ Female ☐ Declined to State	☐ Yes ☐ No

Veteran	Spouse of Veteran
☐ Yes ☐ No	☐ Yes ☐ No

Race

☐ White ☐ American Indian or Alaska Native ☐ Chinese ☐ Japanese ☐ Filipino ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian ☐ Cambodian ☐ Other Asian ☐ Black or African American ☐ Guamanian ☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Multiple Race ☐ Declined to State

Ethnicity

☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State

Relationship Status

☐ Single *(Never Married)* ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined to State

Type of Residence	Does the individual (*Optional*):
☐ House ☐ Apartment ☐ Hotel ☐ Mobile Home ☐ Nursing Home ☐ Residential Care Home ☐ Room and Board ☐ Homeless ☐ Other	☐ Rent ☐ Own ☐ Other

Rural Designation	Unincorporated City	Living Arrangement
☐ Rural ☐ Urban ☐ Declined to State	☐ Yes ☐ No	☐ Alone ☐ Not Alone ☐ Declined to State

Employment Status *(Check One)*	Receive In-Home Supportive Services *(IHSS)?*
☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Declined to State	☐ Yes ☐ No

Is Care Receiver's personal income at or below Federal Poverty Level? ☐ Yes ☐ No ☐ Declined to State

Receive Medi-Cal *(Optional)*	Receive Medicare *(Optional)*	Receive Social Security *(Optional)*	Social Security # *(Optional)*	Have Health Insurance?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No

ADL / IADL RISK FACTORS

8 TITLE III E CARE RECEIVER ACTIVITIES OF DAILY LIVING (ADL) / INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

(Grandchildren exempt)

Activities of Daily Living *(ADL)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Eating	☐	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐

Instrumental Activities of Daily Living *(IADL)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Meal preparation	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐
Med. Mgmt.	☐	☐	☐	☐	☐	☐
Money Mgmt.	☐	☐	☐	☐	☐	☐
Using Phone	☐	☐	☐	☐	☐	☐
Hvy. Housework	☐	☐	☐	☐	☐	☐
Lt. Housework	☐	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐	☐

DISABILITY FACTORS

Disability

☐ Visually Impaired ☐ Hearing Impaired ☐ Physically Impaired ☐ Cognitively Impaired ☐ Declined to State

☐ None

Diabetic	Has Care Receiver been diagnosed with Alzheimer's or a related neurological disorder?
☐Yes ☐ No	☐ Yes ☐ No

CERTIFICATION

9 CERTIFICATION

(To be completed by Interviewer and signed by Client)

I certify that the information on this form, provided to me by the client, is accurate and true to the best of my abilities. I also certify that I have informed the Client that this information may be shared with other providers for the purpose of providing services. Client signature establishes agreement to services.

Completed by *(Print Name)*	Phone
Signature	Date
Client Name (*Print*)	
Client Signature	Date